PRINTED: 09/25/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS235AGZ 09/03/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4509 LILLIPUT LANE GARDEN OF EDEN HOME CARE** LAS VEGAS, NV 89102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 9/3/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and five employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of D. The following deficiencies were identified: Y 050 Y 050 449.194(1) Administrator's SS=F Responsibilities-Oversight NAC 449.194

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

of NRS.

The administrator of a residential facility shall:

1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS235AGZ 09/03/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4509 LILLIPUT LANE GARDEN OF EDEN HOME CARE** LAS VEGAS. NV 89102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 050 Y 050 Continued From page 1 This Regulation is not met as evidenced by: Based on interview, record review and observation on 9/3/09, the administrator failed to provide oversight and direction to the staff to ensure 5 of 5 residents receive the needed services and protective supervision they required. Refer to Tags Y072, Y085, Y103, Y105, Y624, Y991, Y992, Y993, Y994, Y998 and Y999. This was a repeat deficiency from the 5/15/09 through 6/16/09 Complaint Investigation. Severity: 2 Scope: 3 Y 072 449.196(3) Qualications of Caregiver-Med Y 072 SS=F Training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication

approved by the Bureau.

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS235AGZ 09/03/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4509 LILLIPUT LANE GARDEN OF EDEN HOME CARE** LAS VEGAS, NV 89102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 072 Y 072 Continued From page 2 This Regulation is not met as evidenced by: Based on interview and record review on 9/3/09, the facility failed to ensure that 1 of 2 caregivers administering medications completed the required initial medication management training and passed the examination (Employee #3). Interview with Employee #3 revealed she administered medications since she started on 6/1/09, confirmed by the employee's initials/signature on the medication administration record (MAR). Employee #3 stated she took the class today, 9/3/09, but did not pass the test. Employee #2 attended the training and passed the test. He will administer medications until Employee #3 passes the test. This was a repeat deficiency from the 5/28/09 Complaint Investigation. Severity: 2 Scope: 3 Y 085 Y 085 449.199(1) Staffing-CG on duty all times SS=F NAC 449.199 1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more

residents are present at the facility.

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

failed to have evidence of a pre-employment physical and 2-step TB test prior to beginning work. Employee #4 failed to provide evidence of

a 2-step TB test.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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Y 103	Continued From page	e 4		Y 103			
	This was a repeat de State Licensure surve	ficiency from the 10/16, ey.	/08				
	Severity: 2 Scope: 3	3					
Y 105 SS=F	449.200(1)(f) Personi	nel File - Background C	Check	Y 105			
	NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive.						
	This Regulation is not met as evidenced by: Based on record review and interview on 9/3/09, the facility failed to ensure 4 of 5 Employees met background check requirements (Employee #1, #2, #3 and #4). Employee #1 failed to provide evidence of a criminal history statement, fingerprints and state and FBI background check. Employee #2, #3 and #4 failed to provide evidence of a state and FBI background check. Employee #4 failed to show evidence of a criminal history statement. Employee #4 stated the facility had not submitted any of the fingerprints to the repository.						
	Severity: 2 Scope: 3						
Y 172 SS=C	449.209(2) Health an garbage	d Sanitation-Outside		Y 172			
	the facility must be ke	o store garbage outside ept reasonably clean ar uch a manner that rode	nd				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
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CARDEN OF EDEN HOME CARE			4509 LILLIF	RESS, CITY, STA PUT LANE 5, NV 89102	ATE, ZIP CODE		
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Y 172	are unable to get insi once each week, the and the contents of the removed from the present the Regulation is not based on observation.	de the containers. At le containers must be em e containers must be emises of the facility. of met as evidenced by n on 9/3/09, the facility ainers used to store garere covered.	ptied failed	Y 172			
Y 179 SS=D	NAC 449.209 6. All windows that ar	re capable of being ope doors that are left open r the facility must be		Y 179			
	Based on observation to provide screen doc prevent the entry of it ensure a screen was #1 and the large wind room.	ot met as evidenced by: n on 9/3/09, the facility ors on the exit doors to nsects. The facility faile on the window of bedre dow located in the famil	failed ed to oom				
Y 253 SS=F	NAC 449.217	Supplies of Food of a residential facility s	hall	Y 253			

		(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER S GAPPEN OF EDEN HOME CAPE			4509 LILLIF	REET ADDRESS, CITY, STATE, ZIP CODE 509 LILLIPUT LANE AS VEGAS, NV 89102					
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Y 253		at least a 2-day supply o st a 1-week supply of	of	Y 253					
	This Regulation is not met as evidenced by: Based on observation and interview on 9/3/09, the facility failed to provide at least a 1 week supply of canned food in the facility for five residents. Severity: 2 Scope: 3		09,						
Y 274 SS=C	449.2175(5) Service	of Food - Substitutions		Y 274					
	be documented and least 90 days after	or an item on the menu kept on file with the me the substitution occurs posted in a conspicuou ice of the meal.	nu for s. A						
	This Regulation is not met as evidenced by: Based on observation and interview on 9/3/09, the facility failed to ensure menu substitutions were documented and retained for at least 90 days. The facility failed to follow the posted menu for 2 of 2 meals observed in the facility today. The facility failed to document the substitutions.		09, ns 00 menu y.						
	Severity: 1 Sc	ope: 3							
Y 301 SS=D	449.218(2) Bedrooms	s - Window Requireme	nt	Y 301					

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

maintained at the facility.

months except August 2009.

State Licensure survey.

This Regulation is not met as evidenced by: Based on record review on 9/3/09, the facility failed to ensure smoke detectors were tested 11 out of the past 12 months. The facility failed to provide evidence of smoke detector checks for all

This was a repeat deficiency from the 10/16/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
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GARDEN OF EDEN HOME CARE			4509 LILLIPUT LANE LAS VEGAS, NV 89102						
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Y 444	Continued From page	e 8		Y 444					
	Severity: 1 Scope:	3							
Y 530 SS=C	1 1 1 1 2 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1			Y 530					
	NAC 449.260 (e) Provide for the residents at least 10 hours each week of scheduled activities that are suited to their interests and capacities. This Regulation is not met as evidenced by: Based on interview and observation on 9/3/09, the facility failed to provide at least 10 hours of activities for the residents. Employee #4 stated the facility did not have an activity schedule and did not provide any activities for their residents.								
	Severity: 1 Scope:	3							
Y 624 SS=D	449.2702(5) Admission	on Policy		Y 624					
	NAC 449.2702 5. A person may not reside in a residential facility if the person's physician or the Bureau determines that the person does not comply with the requirements for eligibility.								
	Based on observation 9/3/09, the facility fail	ot met as evidenced by n and record review on led to ensure 1 of 5 res e requirements for adm	idents						

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This Regulation is not met as evidenced by: Based on record review on 9/3/09, the facility failed to ensure the medication administration

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Y 895	Continued From page	e 10		Y 895			
	record (MAR) was ac (Resident #1, #2, #3	curate for 4 of 5 resider and #5).	nts				
	Severity: 1 Scope: 3	3					
Y 920 SS=F	449.2748(1) Medication	on Storage		Y 920			
	NAC 449.2748 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key.						
	Based on interview and the facility failed to end to 5 of 5 residents we The facility kept the recloset with a lock. The	ot met as evidenced by: and observation on 9/3/0 asure medications belor are stored in a locked ar asident's medications in a closet was not locked I Employee #1 stated h	nging rea. n a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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GARDEN OF EDEN HOME CARE			4509 LILLII LAS VEGA	PUT LANE S, NV 89102			
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Y 920	Continued From page	e 11		Y 920			
	not have a key to the	closet.					
	Severity: 2 Scope:	3					
Y 924 SS=D	449.2748(4) Medicati	ion / Resident Transfer		Y 924			
	NAC 449.2748 4. Except as otherwise provided in subsection 5, when a resident is discharged or transferred from a residential facility, all medications prescribed for the resident must be provided to the resident or to the facility to which he is transferred. Based on observation on 9/3/09, the facility failed to ensure medications for 1 of 6 residents (Resident #6, discharged resident) were destroyed after he was transferred from the facility. Three bottles of ibuprofen 600 milligram (MG) tables were found in the caregiver's bedroom. Severity: 2 Scope: 1						
Y 991 SS=F	Y 991 SS=F 449.2756(1)(b) Alzheimer's Fac door alarm			Y 991			
	provides care to pers disease shall ensure (b) Operational alarm audible devices which	that: ns, buzzers, horns or oth h are activated when a ed on all doors that may	ner door				
		ot met as evidenced by: n on 9/3/09, the facility t					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X2) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X3) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X4) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X5) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X6) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X7) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X6) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X7) PROVIDER/SUPPLIER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED				
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GARDEN OF EDEN HOME CARE			4509 LILLIF	ADDRESS, CITY, STATE, ZIP CODE ILLIPUT LANE EGAS, NV 89102					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
Y 991 Y 992 SS=F	to ensure an alarm was installed and activated on all exit doors. This is a repeat deficiency from the 10/16/08 annual State Licensure survey. Severity: 2 Scope: 3 2 449.2756(1)(c) Alzheimer's Fac awake staff NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (c) At least one member of the staff is awake and on duty at the facility at all times. This Regulation is not met as evidenced by: Based on observation and interview on 9/3/09, the facility failed to ensure one member of the staff was awake at the facility at all times. Employee #4 presented a staff schedule that failed to have anyone scheduled to work at night. When asked about night coverage Employee #4 stated Employee #2 sleeps in the family room and residents can wake him up if they need something. This is a repeat deficiency from the 10/16/08 Annual State Licensure survey. Severity: 2 Scope: 3		which e and :	Y 991					
∨ 003			Y 993						
Y 993 SS=F	449.2700(1)(0) AIZNE	imer's training		া খখ্					

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residents of the facility are inaccessible to the

This Regulation is not met as evidenced by:

residents.

PRINTED: 09/25/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS235AGZ 09/03/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4509 LILLIPUT LANE GARDEN OF EDEN HOME CARE** LAS VEGAS, NV 89102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 994 Y 994 Continued From page 14 Based on observation on 9/3/09, the facility failed to ensure all knives in the kitchen were inaccessible to the residents. The knives in the kitchen were in a cabinet with a lock but the facility failed to ensure it was locked during the survey. Employee #1 stated he did not have a key to the cabinet. Additionally, the facility failed to ensure a razor in Bedroom #1 was kept in a locked area. Severity: 2 Scope: 3 Y 998 449.2756(f)(4) Alzheimer's Facility-Yard safe Y 998 SS=F NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (f) The facility has an area outside the facility or a yard adjacent to the facility that: (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times.

This Regulation is not met as evidenced by: Based on observation on 9/3/09, the facility failed to ensure the outside of the facility did not jeopardize the safety of the residents. The facility

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This regulation is not met as evidenced by:

family room.

Based on observation on 9/3/09, the facility failed to ensure that toxic substances were inaccessible to the residents. Toxic substances were stored in the laundry room which was not locked. Toxic substances were found unlocked in a desk in the

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING _ NVS235AGZ 09/03/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4509 LILLIPUT LANE GARDEN OF EDEN HOME CARE** LAS VEGAS, NV 89102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 999 Continued From page 16 Y 999 This is a repeat deficiency from the 10/16/08 annual State Licensure survey. Severity: 2 Scope: 3